

Exploring the “Other” Mother: Experiences of the Non-biological Mothers of Lesbian Couples  
Throughout the Pregnancy Process in Central Ohio

Thesis

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## **Abstract**

With increasing numbers of lesbian couples getting married, and the availability of alternative methods of conception, lesbian couples are coming in contact more often with healthcare professionals and the healthcare system through the birthing process. Previous research has shown that lesbian couples have had both positive and negative experiences throughout pregnancy. Given that there is conflicting information on the treatment of this population, it is important to see what types of experiences non-biological mothers of lesbian couples in Central Ohio are having. The purpose of this study is to explore how the non-biological mothers of lesbian couples feel like they are being treated by healthcare professionals and the healthcare system while going through the birthing process (preconception, pregnancy, and post partum), specifically in Central Ohio. Participants participated in face-to-face, semi-structured interviews and described their experiences throughout their partner's pregnancy. These interviews were transcribed, and codes were identified to get a better picture of how the participants perceive that they have been treated. Two participants were interviewed for the study. The study found six codes: support, judgmental attitudes, connections, normalization, experience with lesbian mothers, and treating both mothers equally. These codes can be used to improve service to non-biological mothers of lesbian couples at all different levels of social work intervention. Social workers can use the findings of this study to improve their understanding of work with non-biological mothers of lesbian couples going through the birthing process together. More research needs to be done to get a better understanding of the experiences of non-biological mothers and then what programs can be implemented with healthcare professionals and healthcare systems to improve the overall experience for this population.

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## **Curriculum Vitae**

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## **Fields of Study**

Major Field: Social Work

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## **Chapter 1: Statement of Research Topic**

### **Introduction**

In a 2013 compilation of various demographic data sources, it was determined that there are nearly 650,000 same-sex couples living together in the United States. It was also estimated that 19% of same-sex couples are raising children together (Gates, 2013). There is still limited data on lesbian, gay, bisexual, and transgender (LGBT) families, as 2014 was the first year that the United States census counted same-sex couples that are legally married as “families” (Kellaway, 2014). Even with this limitation on the current data, it is still clear that the number of LGBT families in the United States is growing (Mallon, 2013).

The 2013 U.S. Census reported that there are 23,894 same-sex household in Ohio (United States Census Bureau, 2013). In 2015, a New York Times article listed Columbus, Ohio, as one of the top 15 metropolitan areas with the highest gay population in America (Leonhardt, 2015). In 2014, Columbus received the highest score possible from the Human Rights Campaign’s Municipal Equality Index (MEI). The MEI measures the inclusivity of a municipality’s laws, policies and services for the LGBT population. For example, the 2014 MEI included measures for city non-discrimination laws, the city as an equal employer, and the services that the city offers to LGBT at-risk populations (Human Rights Campaign, 2014a). With these two statistics alone, it is clear that members of the LGBT community often come to live in Central Ohio, and are treated fairly compared to other municipalities in the United States. However, this population comes into contact with so many other groups and professionals throughout the day that may be following the law, but may not be offering the most culturally appropriate service possible.

Culturally appropriate service is also known as cultural competence (Ihara, 2014). In healthcare, cultural competence is the idea that a healthcare professional is able to offer care to a

diverse range of patients. The care provided is sensitive to the personal beliefs and cultural differences of the patient. This includes specific health views that vary culture to culture (National Institutes of Health, 2015; Ihara, 2014).

Cultural competency for healthcare providers with the LGBT population is just beginning to emerge in response to the health disparities that research is finding within this community (Baker & Beagen, 2014). Historically, the LGBT community has not often felt welcome in the healthcare systems. (Adams, McCreanor, & Braun, 2013). Until 1973, homosexuality was still listed as a mental health disorder in the American Psychological Association's *Diagnostic and Statistical Manual of Mental Disorders* (Herek, 2012). This manual, often referred to as the DSM, has standardized diagnostic criteria and descriptions of mental health disorders that mental health professionals use to diagnose these disorders across a variety of patients (American Psychological Association, 2015). LGBT patients have reported healthcare providers using inappropriate and offensive language and refusing to touch some of their body parts. Members of this population who sought out healthcare services are often unnecessarily and embarrassingly questioned about their sexuality (National Women's Law Center, 2014).

Discrimination against LGBT populations in healthcare settings leads to increased health disparities, as people are less likely to see preventative care (American Academy of Family Physicians, 2015). Specifically, research has found lesbian and bisexual women have an increased risk for being overweight and obese, having poor mental health, and abusing drugs and alcohol (Women's Health USA, 2011). Additionally, LGBT persons have higher rates of cancer, mental health issues, physical and emotional violence, obesity, substances abuse, and HIV/AIDS. . These health disparities are then coupled with the lack of legal protections in hospitals for the LGBT population (Kane-Lee & Roth Bayer, 2012).



The Human Rights Campaign (HRC) released a report in 2011, that found a record number of healthcare systems and facilities across the nation are working towards LGBT healthcare equality (Human Rights Campaign, 2011). The HRC releases a yearly Healthcare Equality Index (HEI), which looks at the different policies that the hospitals have concerning inclusivity. These policies include a patient non-discrimination policy, the visitation policies, and the employment non-discrimination policy. The HEI also focuses on LGBT competency training that the staff at the hospital receive (Human Rights Campaign, 2014b). The 2014 HEI noted that LGBT patients not only believe that healthcare professionals will treat them differently, but some believe that they will be refused care. This report also stated that twenty-six healthcare systems were evaluated in Ohio as being a “HEI 2014 Healthcare Equality Leader” (HRC, 2014b). However, only four of the twenty-six leaders, which is only 15%, are located in Central Ohio. It is concerning that a city in the top fifteen for highest LGBT population would only have four healthcare systems that are leading the way in offering culturally competent healthcare services. LGBT patients receive healthcare services from almost all parts of the healthcare system (Makadon, 2011). One specific aspect of healthcare offered here in Central Ohio is fertility services for lesbian couples (Ohio Reproductive Medicine, 2015).

As technology progresses, more lesbian couples are able to access ways of conceiving that were originally impossible (Kranz & Daniluk, 2013). The number of lesbian couples conceiving is growing, which means a growing number of the LGBT population is coming into contact with part of the healthcare system and certain healthcare professionals they may never have had a reason to see before (Dugan, 2014). Lesbian families have a struggle all their own when it comes to the concepts of mothers and motherhood. Being a mother is defined in various ways, but it generally is split between having a child and “being the mother of a child” (Nelson,

2014). There is confusion in healthcare when a child has two mothers. Health care professionals often have no competency training or understanding of how to treat two mothers, or distinguish the roles of two mothers in a child's care. If the healthcare system and healthcare professionals are not appropriately treating members of this population, this group may feel excluded and less likely to seek these services in the future (Nelson, 2014).

### **Purpose of the Study**

As increasing numbers of lesbian couples marry and start families, (Badgett and Herman, 2011), lesbian couples are coming in contact more often with healthcare professionals and the healthcare system through the birthing process. The purpose of this study is to explore what the non-biological mothers of lesbian couples in Central Ohio experience as they go through the birthing process (preconception, pregnancy, and post partum). This includes interactions with healthcare professionals and in the healthcare system. It has been shown that discriminatory healthcare systems deter LGBT patients from getting any type of healthcare (Bogart, Revenson, Whitfield, & France, 2014). Healthcare systems should not be deterring pregnant patients from care; especially since our infant mortality rate is so embarrassingly high in the United States compared to other developed countries (Ingraham, 2014). This study aims to find out what kind of experiences non-biological mothers of lesbian couples are having while their partner goes through the birthing process in Central Ohio.

## **Chapter 2: Literature Review**

### **Cultural Competency in LGBT Healthcare**

Health disparities in marginalized communities arise because of the obstacles these communities face including social, economic, and environmental disadvantages (U.S. Department of Health and Human Services, 2010). In the United States, the *Healthy People 2020* report released by U.S. Department of Health and Human Services (2012) was the very first time that LGBT persons were recognized as a marginalized population that had significant health risks. In a 2009 survey, over half of LGBT respondents reported facing significant discrimination in a healthcare setting, ranging from being refused healthcare to a healthcare professional being physically rough or abusive (Lambda Legal, 2009). Past research has shown that many LGBT persons delay or completely avoid healthcare because of homophobia, both real and perceived, by healthcare professionals and healthcare systems (The Gay and Lesbian Medical Association, 2006).

In addition to the sub-par healthcare treatment that many in the LGBT community receive, there is often also a total legal disregard for legal protections of their families in healthcare settings (Kane-Lee & Roth Bayer, 2012). However, in response to a presidential memorandum on this issue from President Obama, the Department of Health and Human Services created a new regulation for all federally funded hospitals, which stated that each patient has a right to designate any one person as a visitor or medical decision-maker in case of emergency. This includes same-sex partners or spouses (U.S. Department of Health and Human Services, 2011).

A large contribution to this problem may be that health professionals have not been adequately trained to appropriately serve the LGBT community (Harcourt, 2006). Research has

found that there is a lack of LGBT specific education for professionals while they are in school, and that often the professionals that learn LGBT competencies only have done so after encountering a LGBT patient in a clinical setting (Zuzelo, 2014). Providers not only need LGBT cultural training, but also need to assess their own conscious and unconscious biases about the LGBT population and how these biases can effect the healthcare service they are delivering (Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emlet, & Hooyman, 2014). In 2011, New York City Health and Hospitals Corporation became the first public healthcare system in the United States to mandate all employees and professional staff to a LGBT competency training program, to improve the services that their healthcare system is offering, become more inclusive, and reduce LGBT health disparities in their area (New York City Health and Hospitals Corporation, 2011).

### **Making Choices**

For lesbian couples, choosing to become pregnant is a process. Couples report that many things go into the decision to have children, like income level, health insurance to cover fertility services, same-sex parenting laws where the couple lives, and family support (Renaud, 2007). However, in the unique situation that lesbian couples find themselves in, there are more impactful decisions to make. One of the recurring themes mentioned in past research is the consideration that goes into lesbian couples choosing whether or not to disclose their sexuality to healthcare providers. In one interview, a participant explained that her family practitioner told her to lie about her sexuality and bring a male friend along to her fertility appointment; otherwise she would not get care (Wardrop, Zappia, Watkins, & Shields, 2012). One participant that did disclose her sexuality to the healthcare provider was told that impregnating the women and caring for her throughout pregnancy was against his moral and religious beliefs, which is completely unethical in the medical profession (Wilton & Kaufmann, 2001). However, not all

studies conclude that women often decide to hide their sexuality. In a study done in Norway, most participants believed that lesbian women in the healthcare system should accept the uncomfortableness that they feel with healthcare providers and be completely honest (Larrson, & Dykes, 2009). In a separate study, participants believed they had to be open with their doctors and nurses. Unfortunately, it was reported in this study that many times this led to either silence or uncomfortable conversation afterwards (Spidsburg, 2007). In one instance, disclosing the parents' sexuality even led one baby to be put on a special "concern" list at the hospital (Wilton & Kaufmann, 2001).

A couple's decision whether to disclose or not often had an effect on where they sought fertility services. Women had a wide range of experiences at different fertility clinics. Some couples felt that when they walked into a midwife's office, the workers were too interested in their sexual orientation rather than their desire to have a baby (Röndahl, Brunher, & Lindhe, 2009). One mother reported that she felt as though she and her partner had to be the "shining example" of a lesbian couple, or they would set a bad precedent in that clinic for lesbian mothers (Wojnar & Katzenmeyer, 2014). To combat this spotlight feeling, some couples reported that they sought out fertility clinics and doctor's offices that explicitly welcomed lesbian patients (Cherguit, Burns, Pettie, & Tasker, 2013).

When couples went to visit a midwife for the first time, they also looked for how much a midwife included both partners into the conversations, not just the pregnant mother. It was often felt in past research that women thought midwives did the best job possible if they included both mothers throughout the whole pregnancy process (Röndahl et al., 2009). In one particular study, a group of women also agreed that they greatly appreciated when doctor's office or fertility

clinic prepared ahead of time, and the couple did not need to explain to each professional that they saw about their situation (Bucholz, 2000).

### **Heteronormativity in Health Care**

One theme that linked many studies reviewed was the idea that both the healthcare system and pregnancy care in general, are extremely heteronormative (Röndahl et al., 2009; Cherguit et al., 2013; Wilton & Kaufmann, 2001). Heteronormativity is a term that describes how American society sets heterosexuality and opposite-sex couple relationships as the norm. Forms that list only “mother” and father,” and brochures with families that have on families with opposite-sex parents shown are examples of heteronormativity (Head, 2013). Heteronormativity was extremely visible in two main parts of the women’s experiences: parental education and hospital protocol.

#### **Parental Education.**

Women had overwhelmingly negative experiences with parental education classes. First, one couple noted that they were not even offered parental education, and believed this to be because the midwife was uncomfortable with teaching two women together instead of a man and a woman (Röndahl et al., 2009). When in class, nonbiological mothers often felt very out of place. They were not male, so being exclusively with the fathers was uncomfortable, but they were not pregnant so standing with the large group of women also did not seem to make sense (Larrson, & Dykes, 2009). During one couple’s parental education class, an educator refused to use any other terms than “mother” and “father for each situation the class went through. The instructor told the couple, “Well, of course, you realize that most of our classes are attended by normal families...” (Renaud, 2007).

As negative as these experiences tended to be, some women did report that their educators went out of their way to be very inclusive during class time. One woman noted that her midwife used the term “coach” the whole time, instead of inserting pronouns (Brennan & Sell, 2014). To be proactive for the negative experience that they expected, many couples often sought out a lesbian instructor for parenting classes because they believed that they would be more understanding to their situation (Renaud, 2007).

### **Hospital Protocol.**

Lesbian couples also faced heteronormativity in almost every encounter with hospital care that they had. Most often, lesbian couples had their first negative experience with the forms they had to fill out at the hospital. One couple stated that not only every form they got from the hospital was meant for a man and a woman, but also that all the literature they received only had images of families with opposite-sex parents (Cherguit et al., 2013). Even though these forms were simple, they still had a profound effect on how the mothers felt about their treatment in the healthcare system. As one woman stated, “It wouldn’t take that much to make us feel visible – print up a few forms. You don’t want to see ‘father’ on every form” (Röndahl et al., 2009). After birth, one hospital clerk attempted to force a lesbian couple to list a father on the baby’s birth certificate and medical forms. When the couple explained their situation and that the baby did not have a father, the clerk refused to put anything else than “unknown” on the baby’s forms (Bucholz, 2000). On a positive note, one woman shared that she approached the front desk of a hospital in the U.S. after seeing that “husband” and “father” were the only choices on a form she was filling out as the nonbiological mother. After expressing her discomfort and disappointment, the office manager immediately made the change on the standardized forms to “partner” to make them more inclusive (Brennan & Sell, 2014).

Forms were just the beginning of the discomfort that many lesbian couples faced in hospital settings. A nonbiological mother noted that whenever the nurse had to explain something to the couple, it was from a script that exclusively used mother and father. One nurse showing them through the maternity ward consistently said that “the father can sit here” or “the father can come and get coffee here.” She did not believe that there has to specific “special lesbian competence,” but professional staff needed to be more aware of the diversity and vulnerabilities of their patients (Röndahl et al., 2009).

In many instances, because two mothers cannot be married, the mother and the infant would be flagged as a “concern,” either with the biological mother as a single parent or with the lesbian partnership as the reason (Wilton & Kaufmann, 2001). For one couple, this meant that a social worker came in and explained just to the biological mother what services she could offer her as a single parent, even though the nonbiological mother was sitting in the room with them. The couple not only found this completely embarrassing but so frustrating that they had to experience this when it was known to other professional staff that they baby had two mothers (Brennan & Sell, 2014). To avoid situations like this, many women chose to write into their birth plan that they were a lesbian couple (Renaud, 2007). Given that couples in these situation are so greatly affected by the language used by others (Brennan & Sell, 2014), it is not surprising that bad experiences in the hospital that these women are trusting their babies to born in increased the anxiety and negative mental state of nonbiological mothers (Cherguit et al., 2013).

Lesbian women are already more at risk for poor mental health due to many factors, including social stigma and daily discrimination and exclusion (Cochran, Sullivan, & Mays, 2003). For non-biological mothers, there was a large disconnect between what they believed to be their parenting role, and then societal view of them as the non-biological parent (Abelsohn,



Epstein, & Ross, 2013). Given that a significant proportion of men experience what is similar to post-partum depression after the birth of a child (Paulson & Bazemore, 2010), it is not a large stretch to worry about the real possibility of post-partum depression in the nonbiological mother of lesbian couples that have children together (Ross, Steele, & Shapiro, 2005). There has been research that outlines the often overwhelming emotional and physical changes that non-biological women go through during their partner's pregnancy, yet there is almost no research on the mental health and mental health support that non-biological women are offered (Abelsohn, Epstein, & Ross, 2013).

### **Professional Incompetence or Homophobic Attitudes?**

Past stories about poor treatment of same-sex couples have led lesbian couples frequently to enter the healthcare system with a pessimistic outlook. One woman explained how she felt as though many times she assumed that the actions of a professional were because of her sexual orientation, just because she was ultimately expecting it in the end (Cherguit et al., 2013). Many couples also agreed on the fact that they didn't know if they were being treated the same as a heterosexual couple or not, so they couldn't tell why there were uncomfortable tensions or awkward moments with nurses, midwives, doctors and any other professionals that they came into contact with over the course of the pregnancy. The couples from this study agreed that nurses, out of all the healthcare professionals, most needed to be completely comfortable and understanding with lesbian women (Bucholz, 2000). A few women said that they could not help but assume that weird actions by healthcare staff were homophobic, whether that was a fair assumption or not. One woman shared, "When Jessica was born she said 'oh aren't you lucky you didn't have a boy because you wouldn't know how to deal with penis!'" The woman truly

could not decide if the doctor was completely incompetent or homophobic (Cherguit et al., 2013).

Many women stated that they felt that they needed to educate the healthcare professionals working with them. Oftentimes, women believed that the doctors and nurses they saw were curious about their situation in a positive way—that they truly wanted to learn more to offer better care (Erlandsson, Linder, & Haggstrom-Nordin, 2010). However, one woman expressed that when she walked into the OBGYN office, she was there as a parent, not an educator. She believed that her doctor should already know how to work with lesbian couples. Other women were willing to answer questions from the midwives and doctors, but thought that the providers that focused too much on their sexual orientation and not enough on the actual reason they came to see the doctor (Röndahl et al., 2009).

In summary, non-biological mothers of lesbian couples going through the birthing process have had a wide range of experiences in the healthcare system. Existing research has shown that healthcare professionals are not often culturally competent with the LGBT population. Research has also shown that lesbian couples struggle dealing with the heteronormativity that is commonplace throughout the healthcare system, specifically relating to childbirth. However, past research has also highlighted positive experiences that lesbian couples have had throughout all stages of pregnancy. This study aims to explore what experiences non-biological mothers of lesbian couples are having while going through the birthing process in Central Ohio.

## **Chapter 3: Methodology**

### **Research Design**

A qualitative design is used for this research. Qualitative research is used to explore the experiences of human subjects in different contexts. This type of research is especially efficient in obtaining cultural perspectives of different populations (Mack, Woodsong, MacQueen, Guest, & Namey, 2005). This design was used so that each participant would be able to tell her own story from her personal perspective. The research was conducted using a single one on one interview for each participant.

The experiences of these nonbiological mothers were examined. This study was exploratory. The data collected can be used to further investigate aspects of the healthcare system that treats nonbiological mothers of lesbian couples, and improve the system so that this population feels included and accepted.

### **Sampling Procedure**

This study was approved by the Ohio State University Institutional Review Board. The participants were recruited through an information flier (see Appendix A) posted on four different Internet forums. The Internet forums were found through Facebook and were chosen because lesbian women who could fit study criteria frequent them. They were found by searching terms and phrases such as, “lesbian parenting,” “non-biological mother,” “non-gestational mother,” and “non-carrying mother.” Recruitment fliers for the study were also posted at the Stonewall Columbus community center, located in the Short North area of Columbus, Ohio. Stonewall Columbus organizes groups and events for the LGBT community in Central Ohio. Stonewall works to make the LGBT community more visible, as well as educate Columbus about LGBT issues (Stonewall Columbus, 2015). Recruitment was planned from a lesbian parenting group but the group folded due to budget cuts in the organization before the

study began. Recruitment was also planned through fertility clinics in Central Ohio but the main clinic later declined to have a flier posted in its offices.

The recruitment flier asked, “Are you the non-biological mother in a lesbian partnership?” and “Did you participate in the birthing process with your partner?” The flier included basic inclusion criteria (listed below) and the study email. The participants contacted the study email if they were interested in participating. The researcher then responded with an email that included more detailed criteria for participants:

- Must be 18 years or older and capable of providing self-consent
- Must speak English proficiently
- Be the non-biological mother in a lesbian partnership
- Have gone through the birthing process with her partner
- The partner received her prenatal care and gave birth in Central Ohio

Recruitment was open for two months. Four people responded to the recruitment fliers. Two participants were scheduled for interviews, and the other two respondent were ineligible for the study.

### **Data Collection Procedure**

After a participant emailed the researcher, and determined to be eligible for study participation, an interview was scheduled in a Columbus Public Library conference room that was convenient for the participant. The interviews took about thirty minutes each. After the interview was completed, participants were given \$40.00 for their participation in the study. Interviews were audio recorded, and then transcribed by the researcher. Interviews were conducted in a private conference room to ensure participant privacy, and the researcher kept the audio files and transcriptions in password-protected files to ensure privacy for each participant.

The interview was semi-structured, meaning that there was a list of questions to ask the participant, but the participant was encouraged to talk about other topics that she felt were relevant and important to her experience. Semi-structured interviews are effective when there will only be one interview with participants, and when the researcher has some knowledge of what they expect to hear from participants but is also open to new and fresh ideas and perspectives on the same topic (Cohen & Crabtree, 2006).

Participants were asked four different open-ended questions (see Appendix B). These questions were chosen after reviewing previous research in this area, as well as the goal of this study. Questions were worded to focus on the non-biological mother's experience, not the mother that was becoming pregnant. The interview questions followed the natural path of pregnancy with the mothers. The first question was a general question about what went into the decision to conceive a child. This aimed to find how the non-biological mother felt during the decision making process into having a child, as well as her experiences during the conception process. The next question asked about maternity care experiences in the healthcare system. It encouraged participants to share both positive and negative experiences that they had. This question is based off of a question asked by Spidsburg (2007), in a study, "Vulnerable and strong—lesbian women encountering maternity care," that looked at the experiences of lesbian couples with maternity care in Norway. The third question looked at post-natal care experiences with couples. The final question asked the participants for their advice to the healthcare system and healthcare professionals. These four questions used together intended to understand experiences through all parts of the pregnancy process.

## **Data Analysis**

The researcher transcribed the two participants' interviews. Each interview was reviewed five times so the researcher could gain familiarity. Then, using an open focused coding method, basic labels were created for chunks of data. The goal was not to label and group these data based on existing theories, but let meaning emerge.. (Padgett, 2004). Grounded theory analysis is meant to inductively create a theory from a set of data, instead of deductively creating a theory and then testing if a data set fits the theory (Borgatti, 2009). However, with this small-scale study, the researcher is not looking to create or find a theory but to identify emerging themes.

After familiarity was gained, the data were coded. Codes are words or phrases assigned to short sets of data that often either summarize or capture underlying meaning. This data set was coded with three types of codes—descriptive codes, which summarize the topic of the data chunk, in vivo codes, which is a code taken directly from the words of the participant, and process codes, which capture actions (Saldana, 2009). The method of coding the researcher used is outlined by Saldana (2009).

To begin coding, a chart with three columns was constructed. The first column contained excerpts of the transcribed data. The researcher chose the excerpts subjectively. Passages were chosen that described significant thoughts and feelings from the participants related to encounters with healthcare professionals or the healthcare systems. The second column is for primary codes and notes from the researcher. Some data excerpts had obvious in vivo codes, but others had to be analyzed more thoroughly. During a second cycle of coding, some codes were changed as patterns and underlying meaning were found throughout multiple data excerpts. The third column is where the final code is decided. An example of the data chart is included below:

<b>Excerpt from Interview</b>	<b>Initial Coding, Thoughts</b>	<b>Final Code</b>
we met with a couple doctors there and we actually knew one of the nurses personally	Already knew one of the nurses personally	connection
and again we had her mom, her dad, her brother, her sister, our niece, our nephew, and my mom. We had so many people there	So many people there with them	support

A second reader also reviewed and coded the data. Consequently, the two readers met and compared the codes that they found. Areas which there was difference were discussed and consensus was reached. After the data were coded, the codes were not organized into categories. Instead, codes that were found repeatedly in both interviews were identified. Subsequent to the code being made, the decision was made to categorize the codes based on the different practice levels of social work intervention. Therefore, each code was analyzed with how it manifests at the individual, organization, and environmental level.

## Chapter 4: Results

Through the data analysis process outlined in Chapter 3, six codes were identified. These codes not only were evident repeatedly throughout each individual participant interview, but were also shared between both interviews. These six codes are support, connection, judgmental attitudes, normalization, experience with lesbian mothers, and treat both mothers equally.

### Support

The participants spoke about feelings of support throughout all stages of pregnancy. This support came from family and friends, as well as healthcare professionals. Participant one spoke of support from her range of family and friends, explaining:

*The maternity portion of it was great. We have a great support of family friends, both heterosexual and gay and lesbian couples*

Throughout her partner's pregnancy, participant one had others there for her. Speaking about the birth of her child, participant one described the support at the hospital:

*And again we had her mom, her dad, her brother, her sister, our niece, our nephew, and my mom. We had so many people there*

Participant two had support of friends and family, but brought up the support that she felt from healthcare professionals. When describing how welcome she felt at the doctor's offices, participant two said:

*The fertility clinic was clearly used to dealing with lesbian couples, not any whiff of weirdness. They were very supportive.*

This support was important to the participants. Participant one spoke of her experience with a nurse, explaining:



*The nurse that helped in the room when they were, um, I guess putting the embryo in my partner, she ended up retiring but we've kept in great contact that she ended up being our like labor nurse (our doula) so she was in the delivery room when we delivered. So like I had a little more support because I was a little frightful you know going through the experience of watching a baby come out*

Participant one and two brought up how they were supported throughout different parts of the pregnancy.

### **Connection**

The participants mentioned having a connection with a healthcare professional. When this connection was present, the participant had a positive experience. Participant two, while discussing the birth of her baby, explained:

*She went, her labor was really, really fast, and I was talking to the midwives on the phone the whole time we were at the house, and then we drove in to OSU. It was a good experience, it was great*

Having that connection on the phone with the midwife was important to the participant. When a connection wasn't present, the participant had negative experiences. Participant one spoke of her experience after her partner deliver, saying:

*When we got to after delivery, to like a different section where they keep you there for a couple days. It was a little um.. that experience wasn't as warm as we had hoped it to be. Um, but I think its just you have different nurses that come in and out so we didn't get to connect with a certain somebody*

Participant one also discussed a lack of connection when taking her daughter to the pediatrician for the first few months. Participant one recalled:

*And then when we would go to either well check ups, or when [participant's daughter] was ill, we would walk-in. And I would say we would go every couple months, and we always saw a different doctor or nurse practitioner. It seemed like the turn over rate was a little bit higher than we anticipated*

The participant made it clear earlier in her interview that this was not the experience that she was expecting. She was looking for a connection to a certain healthcare professional, as previous connections with doctors and nurses had a positive effect on her experience.

### **Judgmental Attitudes**

Both participants mentioned judgments throughout their interviews. Participant one, speaking when her partner was visibly pregnant, explained:

*But as far as you know being out in public and seeing folks, we've never had any judgments against us or if so it's nothing that we noticed. And we are pretty observant people*

Both participants thought of judgmental attitudes as a bad thing, but both expressed that they had not gotten any judgments against them throughout all stages of pregnancy. Participant two added:

*So yeah, we haven't really ever faced any overt discrimination. Related to having kids, certainly. Not at all*

On top of not facing judgments throughout pregnancy, participant one also believed that leaving judgments out of the healthcare system was important to competent care with lesbian couples.

Participant one stated:

*And if someone is bringing you business, you don't want to have any judgments against them, and you want to treat them equally amongst everyone*

## Normalization

Participants one and two expressed how same-sex couples having children together was becoming normal in Central Ohio, and that healthcare professionals are getting used to it.

Participant two believes that Columbus is already far ahead in recognizing same-sex couples.

She explained:

*Yeah, the Columbus institutions seem to be pretty good. I mean, I think there are openly gay people in all parts of the government and in all of the agencies... Being gay in*

*Central Ohio at this point is less of a stigma, I think. I think that doctors are used to it*

Participant one had multiple experiences with feeling as though same-sex couples with children are normal in Central Ohio. At first, participant one didn't know whether her experiences were normal or not. Participant one described the fertility process with her partner, saying:

*and we tried just doing the inseminations for about 14 months straight. So emotionally, and financially that was just "ahhhh" you know hard to get over the fact it wasn't happening, but through the process we learned that there are many other couples, heterosexual couples, that have the same issues*

Participant one also spoke of educating healthcare professionals about lesbian couples with children and making them more visible. After an uncomfortable situation with a nurse, participant one explained:

*that was uncomfortable. We were loyal people to where we want to educate and let it be known that this is getting to be like normal, so we did continue end up going to this pediatrician's office*

Participant one thought that it was part of her obligation as a lesbian mother to help educate and normalize this process.

### **Experience with Lesbian Mothers**

Both participants shared experiences that highlighted the importance of a healthcare professional having experience with lesbian couples. Participant two made it clear that all of the healthcare professionals and healthcare systems she came in contact with had experience with lesbian couples. Describing her interactions with different healthcare professionals at different stages, participant two recalled:

*The midwives, the same. They were all very, I don't know how many, they have some amount of same-sex couples there but no, everything was fine there. And then the hospital too. Every step of the way, every sort of person we interacted in the hospital was great.*

Participant one, in contrast, saw what a lack of experience with lesbian couples can unfold as in a healthcare setting. Participant one and her mother-in-law brought her sick daughter to the doctor's office. After going through questions about the participant's daughter's health, the nurse asked if anyone was sick in the home. Participant one mentioned that her partner wasn't sick. Participant one shared:

*And the nurse goes "Well, who is [participant's partner]?" like kind of "who's [participant's partner]?" And [partner's mother] goes "that's her mom.." And she kind of looks at us, and I would said she's in her mid to upper 50s and she goes, "well who are you?" And I was like "well, I'm her mom too." And she looked at [partner's mother] and just looked and then [partner's mother] goes "she has two mommies!" And the nurse was like "Oh...ok..." And that was uncomfortable*

The nurse was not negative, but unaware and unwelcoming, even though this was the same doctor's office participant one had been bringing her daughter to regularly since birth.

Experience, or a lack of experience, working with lesbian couples in a healthcare setting made a difference to the participants.

### **Treating Both Mothers Equally**

With the complicated relationship dynamics and expectations already in place with a non-biological mother, the participants both remarked on times they felt equal or unequal treatment as the "other" mother. Participant two spoke highly of her treatment from healthcare professionals. She explained:

*We didn't have any bad experiences. All the providers, everyone we have had, has always been good with both of us*

Participant one had a more complex experience with equal treatment. In Ohio, gay marriage is illegal, so pregnant women in a lesbian partnership are listed as "single mothers" in the hospital when they deliver. This already puts the non-biological mother out of any equal position as a mother of the child. Participant one shared how a social worker tried to alleviate this unfair treatment for the couple, recalling:

*And a social worker ended up coming in because they see a single parent, since we have to because we are not married. So single parent, so they had to come in and talk. And we are answering questions and sitting there on the bed, you know with [participant's partner], being a social worker herself, is just like this is kinda annoying but this is what they have to do. So we are answering the questions and even like three questions later she is like, "you know what, I think I have all the information I need." So she left and that was good*

Although the organization and laws in this state set the couple up unfairly for exclusive treatment, the healthcare professional understood the situation and remedied the unequal treatment the mothers would have received.

## **Chapter 5: Discussion**

### **Summary of the Results**

As outlined in Chapter 4, there are six codes that emerged from the data. These six codes are support, connection, judgmental attitudes, normalization, experience with lesbian couples, and treat both mothers equally. These codes include feelings that non-biological mothers had throughout their partner's pregnancy, as well as feelings about actions by healthcare professionals that made a difference in each participant's experience.

Some of these codes are consistent with previous research about the experiences of nonbiological mothers throughout all stages of pregnancy. Previous research stressed that lesbian couples appreciated when doctor's offices had experience with lesbian couples and welcomed them (Bucholz, 2000; Cherguit et al., 2013), which is consistent with the participants in this study. Participant two also expressed in her interview how it was meaningful when a healthcare professional treated both her and her partner the same. This sentiment echoes conclusions found in previous research (Röndahl et al., 2009), that lesbian women feel most comfortable when both partners are included equally in discussions with healthcare professionals. Participants in this study, as well as participants in past research (Wilton & Kaufmann, 2001), both struggled with the fact that the hospitals did not recognize lesbian partnerships as legitimate and the biological mothers were listed as "single mothers" or a patient with a "special concern." Participant one and participant two mentioned the close connections they formed with healthcare professionals. These connections ensured their comfort and helped form another support network in addition to family and friends. Past research has emphasized this point as well, even going further to specify that nurses being competent with lesbian couples made a huge difference, as this is the healthcare professional that the couples come into contact with the most (Bucholz, 2000).

Multiple codes identified in this study are also found in past research, but with different outcomes for the participants. The participants in this study identified how lesbian couples having children together in Central Ohio is becoming normal, and people should recognize it as such. However, in past research (Renaud, 2007), healthcare professionals told participants that “normal” families had a mother and a father. Past research showed that non-biological mothers often felt judged or uncomfortable by healthcare professionals (Brennan & Sell, 2014; Røndahl et al., 2009; Wojnar & Katzenmeyer, 2014).

Participants in this study often described the importance of support in their experiences in the healthcare system. This came from both family and friends, as well as healthcare professionals. This was an aspect of the experience of the participants in this study that was not found in past research.

### **Limitations**

This study has multiple limitations. First, the study is exploratory. It is meant to identify experiences that non-biological mothers have had in the healthcare system and with healthcare professionals, not create theories or make definitive conclusions on what needs to change. Second, there were two participants. The findings reflect two different women’s experiences with the healthcare system and healthcare professionals. Although their experiences are important to note, they may not be the norm. The recruitment and sampling process also puts a limitation on the findings of the study. Participants were recruited through convenience sampling. Every participant that contacted the study and fit the recruitment criteria was accepted. The study information was only posted online and at the Stonewall community center. If there information was posted at a larger variety of locations there could be a larger, more diverse group of respondents.



## **Implications**

The implications of this research span many different levels of social work intervention. These include social work practice, and social work at an organizational level.

### **Social Work Practice.**

Social workers working with this population can incorporate appropriate use of all six codes into their practice. As social workers, there should be no judgments of patients that are seen. The National Association of Social Workers (NASW) code of ethics mandates that “social workers respect the inherent dignity and worth of the person” (National Association of Social Workers, 2008). This includes being aware of cultural differences. However, it is important to know that these patients may be negatively affected by the judgments of others. Making a concerted effort to form a positive connection with non-biological mothers of lesbian couples who are going through the birthing process can make the mother feel more supported. Social workers can also find ways to either gain competence or experience with lesbian couples, but also hold trainings for other healthcare professionals so that they may gain knowledge as well. The NASW code of ethics code 1.05 (c) states:

Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability (NASW, 2008).

Social workers should be proactive about becoming culturally competent with lesbian couples. Social workers can not only improve their own individual practice with lesbian couples, but also help change the experience that non-biological mothers have in the healthcare system.

### **Organizational Level.**

There were multiple times participants expressed negative experiences that could have been avoided if the organization (in this case, healthcare systems) were more aware and accepting of their needs. One point that stands out most is the fact that the biological parent of the lesbian couples is listed as a single mother. Although the hospital has no control over the marriage laws in its states, there could be a designation made for lesbian couples in committed partnerships. Organizations can be inclusive of committed partners that are only not married because of the law. Another way hospitals can improve their service to non-biological mothers is to train healthcare staff to be competent with this population. Participant one had a very uncomfortable experience with a nurse that may have been avoided if the nurse had received information or training on working with lesbian couples. Healthcare systems can also continue to help make it known that lesbian couples with children is normal. This can entail including families with same-sex parents on literature and making sure that all forms and scripts are inclusive of families that have same-sex parents. This is a component of the culture of the organization. Organizational culture includes multiple components, but most pertinent to this study is the way that an organization not only treats its employees, but also how it treats customers and chooses to conduct its business (WebFinance, 2015). Encouraging organizations to create a culture that is completely inclusive and aware of the diversity of same-sex couples having children can help make it known to all that this is becoming normal in society.

### **Advocacy.**

From the findings of this study, there are a few different concrete changes that social workers could advocate for to improve the experiences that non-biological mothers of lesbian couples going through the birthing process together are having. To improve the equal treatment

of both mothers, social workers can advocate for fair marriage and parenting laws for lesbian couples. This ensures that the government, and therefore the organizations that follow these standards, treat both mothers equally. Social workers can also advocate for better training for healthcare professionals. Not only could social workers advocate for these trainings, but also use their knowledge as culturally competent professionals to lead these trainings and increase awareness of the importance of competently serving this population. Finally, social workers can advocate for better education for social work students about work with the LGBT population in a healthcare setting, and even non-biological mothers of lesbian couples having children together specifically. If social workers can go to into the field with a better understanding of how to competently serve this population, they can share their knowledge with other professionals to improve the overall treatment of non-biological mothers.

### **Future Research Recommendations**

Given the lack of research concerning lesbian couples throughout the birthing process, including the small sample size of this study, it is clear that more research needs to be done to see what non-biological mothers of lesbian couples going through the birthing process are experiencing. The more perspectives of women in this situation that can be obtained, the clearer the picture can become of their experiences. To also gain better conclusions on the experiences that non-biological mothers are having specifically, the research questions would have to be redone. Although both participants answered positively about their experiences, both spoke almost exclusively using “we” and “us” or talking about their partner’s experience. So even though the interviews still got an overall view of what the experience was like for both women, it is important to find a better way to get more participant specific information.

The last recommendation for future research is to truly look into what hospitals that serve lesbian couples well throughout the birthing process are doing to appropriately set up their care and inform their staff. The more that research examines this process and is able to create a plan that will make an inclusive setting, the easier it would be to replicate this process in other places. The past research with lesbian couples going through the birthing process is not favorable with healthcare professionals and the healthcare system. If a training program can be created that informs professionals on the specific needs of this population, lesbian couples can receive culturally competent care and feel included in a healthcare setting. This will help close a gap in one part of healthcare equality, and allow all women to get fair care during the pregnancy process.

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## Appendices

### Appendix A:

Are you the non-biological mother in a lesbian partnership? If so, we want to learn from you!

- We are seeking about 15 volunteers to participate in a study through the **OSU College of Social Work** about the experiences of non-biological lesbian mothers throughout the birthing process (pre-conception, pregnancy, post-partum) in Central Ohio
- One-on-One interviews will be conducted
- Participants must be over 18 years of age
- Interviews will last 45-60 minutes
- Participants will receive a \$40.00 cash

If you would like to hear more about the study or are interested in participating, please email: **[othermotherstudy@gmail.com](mailto:othermotherstudy@gmail.com)**

Participants will be accepted until the study is full



## **Appendix B:**

### **Interview Question Guide**

1. What kind of experiences did you have while working with your partner to conceive?
2. What was your experience with maternity care? Please share both positive and negative experiences, especially those with healthcare professionals or the healthcare system.
3. What experiences did you have after your child was born?
4. If you had one piece of advice for healthcare professionals, or the healthcare system in general, to make the process smoother in the future, what would it be?